STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - HOME HEALTH NURSING SERVICES

8. Medical necessity for a second visit on the same day must be well documented.
9. NMAP recognized enterostomal therapy visits as a skilled nursing service.
10. NMAP applies the following limitations to nursing services (RN and LPN) for adults age 21 and older:
    a. Per diem reimbursement for nursing services for the care of ventilator-dependent clients shall not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average shall be computed using nursing facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period.
    b. Per diem reimbursement for all other in-home nursing services shall note exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level. This average shall be computed using the Extensive Special Care 2 case-mix nursing facility interim rates which are effective January 1 of each year, and applicable for that calendar year period.

    Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30-day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.)

ATTACHMENT 3.1-A
Item 7b
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - HOME HEALTH AGENCIES - HOME HEALTH AIDE SERVICES

1. Home health aide services must be -
   a. Necessary to continuing a medical treatment plan;
   b. Prescribed by a licensed physician;
   c. Recertified by the licensed physician at least every 60 days; and
   d. Supervised by a registered nurse.
2. Payment for home health agency services must be authorized by the Central Office.
3. Prefilling syringes with insulin for a blind diabetic is reimbursed only as a professional nursing service. Home health agencies will not be reimbursed for prefilling insulin syringes for a blind diabetic by a home health aide.
4. Home health aide services may not exceed eight hours per day or forty hours of care in a seven-day period.
5. Skilled nursing visits are not a prerequisite for the provision of home health aide services.

Transmittal # MS-93-15

Supercedes Approved JAN 26 1994 Effective NOV 17 1993

Transmittal # MS-83-10

ATTACHMENT 3.1-A
Item 7c (Page 1)
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES SUITABLE FOR USE IN THE HOME

The Nebraska Medical Assistance Program covers the purchase or rental of durable medical equipment, medical supplies, orthotics, and prosthetics that meet program guidelines when prescribed by a physician or other licensed practitioner whose licensure allows prescribing these items (M.D., D.O., D.P.M.). To qualify as a covered service under NMAP, the item must be medically necessary and must meet the definitions in state regulations.

NMAP does not cover items that primarily serve personal comfort; convenience; or educational, hygienic, safety, or cosmetic functions; or new equipment of unproven value and/or equipment of questionable current usefulness or therapeutic value.

NMAP does not generally enroll hospitals, hospital pharmacies, long term care facilities; rehabilitation services or centers, physicians, physical therapists, speech therapists, or occupational therapists as providers of durable medical equipment, medical supplies, or orthotics and prosthetics. Home health agencies may provide durable medical equipment and oxygen only.

Durable medical equipment is equipment which -

1. Withstands repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an illness or injury; and
4. Is appropriate for use in the client's home. This generally does no include long term care facilities.

Coverage conditions for individual services are listed with the procedure code descriptions.

Transmittal # MS-93-15

Supercedes Approved JAN 2 6 1994 Effective NOV 1 7 1993

Transmittal # (New Page)

ATTACHMENT 3.1-A
Item 7c (Page 2)
Applies to Both
Categorically and
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - MEDICAL SUPPLIES, EQUIPMENT, AND APPLIANCES
SUITABLE FOR USE IN THE HOME

NMAP covers medical supplies listed in the coverage criteria and procedure code list when prescribed for medical care in the client's home. Items not specifically listed may not be covered by NMAP. Coverage for medical supplies does not generally include clients residing in NF's or ICF/MR's.

NMAP does not cover, as medical supplies, personal care items such as non-medical mouthwashes, deodorants, talcum powders, bath powders, soaps, dentifrices, eye washes, contact solutions, etc. NMAP does not cover, as medical supplies, oral or injectable over-the-counter drugs and medications.

NMAP covers orthotic devices when medically necessary and prescribed to support a weak or deformed body member or restrict or eliminate motion in a diseased or injured part of the body. Coverage includes braces, orthopedic shoes and shoe corrections, lumbar supports, hernia control devices, and similar items. NMAP covers prosthetic devices when medically necessary and prescribed to replace a missing body part. Orthotics and prosthetics are covered for clients residing in NF's and ICF/MR's. NMAP does not cover external powered prosthetic devices.

NMAP covers only one pair of orthopedic shoes at the time of purchase. Except when size change is necessary due to growth and/or when diagnosis indicates excessive wear, NMAP allows only one pair of shoes in a one-year period. Orthopedic shoes and shoe corrections are not covered for flexible or congenital flat feet.

Prior authorization is required of payment of rental and purchase of the items listed in state regulations as requiring prior authorization.

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Transmittal # (New Page)

ATTACHMENT 3.1-A
Item 7d
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - HOME HEALTH SERVICES - PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH PATHOLOGY AND AUDIOLOGY

1. Payment for home health agency services must be authorized by the Central Office.
2. Physical therapy, occupational therapy, and speech pathology and audiology provided by a home health agency are covered by NMAP only when there is no other method for the client to receive the service. Substantiating documentation must be attached to the claim.
3. Physical therapy services provided by a licensed physical therapist who is employed by the home health agency are consider home health agency services. There services are subject to the seam limitations as services provided by independent physical therapists.
4. Occupational therapy services provided by a qualified occupational therapist employed by the home health agency are considered home health agency services. These services are subject to the same limitations as services provided by a qualified occupation therapist in a hospital or nursing home or by an independent therapist.
5. Speech pathology and audiology services provided by licensed speech pathologist or audiologist employed by the home health agency are considered home health agency services. These services are subject to the same limitations as services provided by independent speech pathologists or audiologists.

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Transmittal # MS-83-10

ATTACHMENT 3.1-A
Item 8
Applies to Both
Categorically and
Medically Needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - PRIVATE DUTY NURSING SERVICES

NMAP applies the following limitations to nursing services (RN and LPN) for adults age 21 and older:

1. Per diem reimbursement for nursing services for the care of ventilator-dependent clients shall not exceed the average ventilator per diem of all Nebraska nursing facilities which are providing that service. This average shall be computed using nursing facility's ventilator interim rates which are effective January 1 of each year, and are applicable for that calendar year period.
2. Per diem reimbursement for all other in-home nursing service shall not exceed the average case-mix per diem for the Extensive Special Care 2 case-mix reimbursement level. This average shall be computed using the Extensive Special Care 2 case-mix nursing facility interim rates which are effective January 1 of each year, and applicable for that calendar year period.

Under special circumstances, the per diem reimbursement may exceed this maximum for a short period of time - for example, a recent return from a hospital stay. However, in these cases, the 30-day average of the in-home nursing per diems shall not exceed the maximum above. (The 30 days are defined to include the days which are paid in excess of the maximum plus those days immediately following, totaling 30.)

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Supercedes Approved JAN 26 1994 Effective NOV 17 1993

Transmittal # (New Page)

"Substitute per letter dated 11/12/98"

ATTACHMENT 3.1-A
Item 9
Applies to both categorically and medically needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - CLINIC SERVICES

Community mental health centers must be licensed and approved by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), American Osteopathic Association (AOA), Commission of Accreditation (COA), or Combustion on Accreditation of Rehabilitation Facilities (CARF). Certification through the Nebraska Department of Health and Human Regulation and Licensure will fulfill the accreditation requirements. Services provided by community mental health centers are limited to medically necessary acute psychiatric services.

Day treatment services are limited to a half-day or full-day rate, established on the basis of each facility's cost report which is reviewed annually.

Prior authorization is not required for medically necessary outpatient psychotherapy services.

Testing and evaluations must be performed by a licensed psychologist or under the supervision of a licensed psychologist.

Transmittal # MS-95-13

Supersedes Approved FEB 09 1998 Effective 7/25/95

Transmittal # MS-90-4

ATTACHMENT 3.1-A
Page 3, Item 9
Applies to Both
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - CLINIC SERVICES

Services Provided in Ambulatory Surgical Centers: NMAP covers facility services provided in ambulatory surgical centers (both free-standing and hospital-affiliated) under the following limitations.

The "facility fee" includes payment for services and items provided by an ASC in connection with a covered surgical procedure.

Covered surgical procedures include the procedures on Medicare's list of covered ASC procedures and state-defined procedures, which includes tubal ligations, vasectomies, and certain dental services.

The ASC may also provide services other than those included under the facility fee. These services are limited under the appropriate category (durable medical equipment, medical supplies, ambulance services, etc.) listed elsewhere in the Title XIX Plan.

Transmittal # MS-84-16

Supercedes Approved 10/11/84 Effective 8/1/84

Transmittal # (new page)

ATTACHMENT 3.1-A
Page 3, Item 9
Applies to both
categorically and
medically needy

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - CLINIC SERVICES

ABORTIONS:

Payment for abortions under the Nebraska Medical Assistance Program is limited to those abortions for which FFP is currently available.

State Plan
Trans. No. MS-81-6
Supersedes MS 80-13
Submitted 9-28-81
Approved 10-01-81
Effective 6-5-81

file

ATTACHMENT 3.1-A
Page 3, Item 9
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Nebraska

LIMITATIONS - CLINIC SERVICES

FEDERALLY-QUALIFIED HEALTH CENTERS

To be considered a federally-qualified health center (FQHC) for the Nebraska Medical Assistance Program, as allowed by section 6404 of P.L. 101-239, a health center must furnish proof that the United States Public Health Service has determined that it is qualified under Sections 329, 330, or 340 of the Public Health Service Act, or that it qualifies by meeting other requirements established by the Secretary of Health and Human Services.

Transmittal # MS-90-5

Supercedes Approved 4/18/90 Effective 4/1/90

Transmittal # (new page)